Maryland Medicaid Pharmacy Program Fax: (866) 440-9345 Phone: (800) 932-3918	**Sublocade or Brixadi Prior Authorization Form**	Maryland DEPARTMENT OF HEALTH

PATIENT'S NAME: **Date:**

DOB: MD Medicaid Number:

PRESCRIBER'S NAME: NPI #:

Phone #: Fax #: .

CONTACT PERSON'S NAME:

Phone #: Fax #:

☐ Must be 18 years old ☐ Diagnosis of moderate to severe Opioid Use Disorder (OUD)

Medication: ◯ Sublocade ◯ Brixadi Strength: Quantity: Refills:

Directions for use:

Y	N	**Sublocade**
◯	◯	Has initiated treatment with a transmucosal buprenorphine-containing product delivering the equivalent of 8 to 24mg of buprenorphine daily, followed by dose adjustment for a minimum of 7 days

Quantity limit (QL) – one injection (any dose) every 28 days
Initial authorization approval for 90 days
Renewal authorization for 12 months

Y	N	**Brixadi**
◯	◯	Has initiated treatment with a single dose of a transmucosal buprenorphine-product or is already being treated with buprenorphine

Quantity limit (QL) –Weekly: 32 mg/7 days Monthly: 128mg/28 days
Initial authorization approval for 90 days
Renewal authorization for 12 months

☐ I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

☐ MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original

Prescriber's Signature **Date:**

Fax this completed form to 866-440-9345. Incomplete forms will not be reviewed.